

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LTC Residents Protection

PRINTED: 07/02/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Director's Office	JUL 30 2009 (X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FOULK MANOR NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 FOULK ROAD WILMINGTON, DE 19803	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from June 9, 2009 through June 12, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The census on the first day of the survey was ten (10). The survey sample totaled 5 residents (R1 through R5), which included review of four (4) active and one (1) closed record.	F 000	Responses to the cited deficiencies do not constitute an admission agreement by Foulk Manor North of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.	
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's policy, it was determined that the facility failed to ensure that three (3) (E9, E10 and E11) of fifteen (15) sampled staff received annual abuse training. Findings include: Three staff (E9, E10 and E11) of 15 sampled revealed no record of annual abuse training. E9 was hired 11/12/98, E10 was hired 7/24/89, and E11 was hired 9/24/04. An interview with E3 (Assistant Director of Nursing) confirmed these findings. Review of the Abuse Prohibition and Prevention Program policy, dated 11/15/08, stated that all employees will be provided training during orientation and at a minimum on an annual basis.	F 226	No residents were cited or identified by the stated deficiency. The three (3) staff members will be in-serviced on abuse training. No residents have been identified. Three (3) staff members will be in-serviced on abuse training. The Human Resources Manager will schedule monthly training, in-servicing and orientation for new hires and annually for existing staff. The Human Resources Manager will conduct a total review of all employee records to ensure compliance with abuse training and report findings at the next quality assurance meeting on July 20, 2009. Any staff not in compliance will be in-serviced. All findings will be reported during quarterly quality assurance meetings for analysis and follow-up recommendations.	7/30/09
F 248	483.15(f)(1) ACTIVITIES	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

McGraw C. Gray, MHA Executive Director July 29, 2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248 SS=D	<p>Continued From page 1</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that one (1) resident (R3) out of five (5) sampled received an ongoing program of activities designed to accommodate interests and help enhance physical, mental and psycho-social well being in accordance with the resident's comprehensive assessment. Additionally, the facility failed to ensure that a movie and an exercise program engaged all of the residents who attended the activity. Findings include:</p> <p>1. R3 was admitted on 4/16/09 with diagnoses that included spinal stenosis, dementia, TIA (transient ischemic attack) and degenerative joint disease. According to R3's admission Minimum Data Set (MDS) assessment dated 4/28/09, her cognitive skills for daily decision making were "moderately impaired-decisions poor; cues/supervision required." R3 was totally dependent of staff for all activities of daily living (ADL), had unsteady gait and a wheelchair was her primary mode of locomotion. R3's preferred activities setting was the day/activity room.</p> <p>According to an "Activity Assessment" dated 4/15/09, R3's interests included theater, movies, site seeing, dancing, gardening, painting (water color), reminiscing, country music, religious</p>	F 248	<p>Resident #3 was provided with a radio. The facility has arranged to take Resident #3 on daily walks and encourages her to participate in exercise. Family photos and a television have been placed in her room.</p> <p>The Director of Recreation will review all resident records, updating care plans to include new interventions as needed and target resident rooms for personalization.</p> <p>The Director of Recreation will add an additional staff member, as necessary, when a large group of residents are participating in exercise programs.</p> <p>The Director of Recreation will solicit movie recommendations from the residents during monthly Resident Council meetings to determine which movies residents would most enjoy watching.</p> <p>The Director of Recreation will report all findings at the quarterly quality assurance meetings.</p>		7/30/09

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F 248	<p>Continued From page 2</p> <p>music, pets, inspirational readings and communion.</p> <p>Review of R3's "Resident Daily Activity Program Participation Log" for 4/09 through 6/09 revealed that the facility failed to offer R3 activities in which she had expressed an interest on the 4/15/09 "Activity Assessment."</p> <p>Observation of R3's room on 6/10/09 revealed that she did not have a radio to listen to music, a television to watch movies that would reflect her interests, potted plants or pictures on the wall to help stimulate her interest and enhance her mental and psychosocial well being. The room was always dark.</p> <p>During an interview with E8 (Director of Recreation) on 6/10/09 at 3:05 PM, the surveyor asked if she had seen R3's room. E8 stated that she had not seen the resident's room. E8 also stated that E20 (activity assistant) was responsible for ensuring that R3 attended activities and also wrote the progress notes. When the surveyor and E8 reviewed R3's activity log, E8 had difficulty identifying the documented activity codes on R3's daily activity log. E8 confirmed that R3's activity attendance was not monitored and evaluated by her to ensure that this resident's interests were being met.</p> <p>2. Observation on 6/9/09 at 10:30 AM, revealed that an exercise program was in session in the second floor dining room, conducted by one person. There were approximately 10 residents in the room, some were participating and some were not. There was no additional staff present to encourage the residents.</p>	F 248			

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F 248	Continued From page 3 3. On 6/10/09 at approximately 4:15 PM, SSR9 stated that she left the movie playing in the second floor lounge after 5 minutes because there was a "bunch of kids hitting each other over the head, I'm not interested in that." A subsequent observation of the second floor lounge revealed six (6) female residents seated in wheelchairs, three (3) of which had their eyes closed and appeared to be dozing. A cartoon tape entitled "Madagascar Escape 2 Africa" was playing on the television. When one (1) resident was asked if she was enjoying the movie she stated, "Eh its all right, there's nothing else to watch." This finding was confirmed with E1(Administrator), E2 (DON) , E3 (ADON) and E19 (RN consultant) on 6/12/09. They also stated that the nursing staff had picked the movie for the residents because they did not want them all sitting at the nurse's station.	F 248			
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	Resident #3 was provided with a radio. The facility has arranged to take Resident #3 on daily walks and encourages her to participate in exercise. Family photos and a television have been placed in her room. The Director of Recreation will review all resident records, updating care plans to include new interventions as needed and target resident rooms for personalization. The Director of Recreation will add an additional staff member, as necessary, when a large group of residents are participating in exercise programs.		7/30/09

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F 279	<p>Continued From page 4</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Cross-refer to F248 Based on record review and interview, it was determined that the facility failed to develop a care plan for one (1) resident (R3) out of 5 sampled, in a timely manner to meet this resident's activity needs. Findings include:</p> <p>According to R3's MDS assessment dated 4/28/09, her cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required."</p> <p>Review of R3's clinical record revealed that the facility failed to initiate an activity care plan within 24 hours of admission and/or 7 days after the completion of the comprehensive assessment. The facility developed a care plan on "R3 is new to (name of facility)" on 5/22/09, five weeks after admission.</p> <p>The goal of this care plan was that R3 "will adjust to facility by attending out of room activities 1 time a week in 90 days." The intervention included "Provide (R3) with a calendar; prefers to stay in room; will accept room visits 3x a week; Remind of Mass/Communion/Rosary weekly." The care plan failed to identify R3's interests in order to enhance her ability to meet her needs in</p>	F 279	<p>The Director of Recreation will solicit movie recommendations from the residents during monthly Resident Council meetings to determine which movies residents would most enjoy watching.</p> <p>The Director of Recreation will report all findings at the quarterly quality assurance meetings.</p>		

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F 279	Continued From page 5 accordance with her cognitive skills and comprehensive assessment.	F 279		
F 280 SS=D	Interview with E8 (Activity Director) on 6/10/09 confirmed this finding. 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Cross refer to F327 Based on record review and interview, it was determined that the facility failed to ensure that the care plan was revised by a team of qualified persons after each assessment for one (1) resident (R2) out of 5 sampled. Findings include:	F 280	Resident #2's care plan has been updated to reflect measures to be taken to prevent hydration. The food & beverage department sends 480cc fluids with each meal and nursing provides 180cc fluids every shift. The Director of Nursing or designee will evaluate all residents I & O for fluid needs vs. actual intake and formulate a plan of care to meet their needs. The Director of Nursing or designee will in-service the nursing staff on the facility's I & O hydration policy which outlines the procedure for alternatives if residents do not meet fluid intake needs. The Director of Nursing or designee will monitor residents I & O daily for two (2) weeks until compliant, then weekly, then monthly for six (6) months for analysis and recommendations and will report findings during quarterly quality assurance meetings.	7/30/09

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F 280	Continued From page 6 R2's care plan entitled, "Nutrition: Therapeutic Diet R/T HTN," last revised on 4/9/09, included the interventions "assist with meals as needed...Monitor for s/s (signs and symptoms) of dehydration." A second care plan initiated on 4/9/09 for "Potential for complications R/T (related to) suprapubic catheter (UTI, dehydration...etc.)" included interventions "Monitor urinary output for amount...q (every) shift...Notify MD of any changes...I&O (Intake and output) q shift..." Both care plans failed to reflect measures to be taken to prevent dehydration and failed to identify R2's daily fluid needs. Additionally, the care plan failed to identify alternate approaches should R2 refuse fluids and not meet his daily fluid requirement. This finding was confirmed with E2 (DON) and E5 (RN) on 6/11/09 at 11:45 AM.	F 280			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that one (1) resident (R1) out of five (5) sampled received services in accordance with accepted professional standards and practices. Findings include: According to the AMDA (American Medical Directors Association) "Clinical Practice Guideline (CPG) for Pressure Ulcers for Practitioners" weekly change monitoring of the pressure ulcer	F 281	Resident #1 had two wounds. One wound has healed and the second LL posterior thigh open wound has a treatment in place and is currently healing. All residents with wounds will be reviewed by weekly measurements. The Director of Nursing or designee will conduct weekly, documented wound rounds, identifying measurements with unit nurse managers and develop an individualized care plan related to wound care.		7/30/09

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F 281	<p>Continued From page 7</p> <p>includes obtaining the size of the ulcer.</p> <p>Review of R1's nurse's notes, dated 2/3/09 revealed that the resident had an open area on her left posterior thigh. An initial wound evaluation, completed on 2/3/09 included measurements, however there were no further weekly measurements documented in the clinical record. A nurse's note, dated 2/27/09 and timed 10 PM stated that the treatment to the left thigh was discontinued and the area was healed.</p> <p>On 3/9/09 an initial wound evaluation, with measurements, noted an open red area to the left buttock. A weekly measurement was documented for 3/17/09, however there were no subsequent measurements found. It was unclear in the clinical record when this open area healed.</p> <p>A nurse's note, dated 4/28/09 noted that the wound to the left posterior thigh reopened. An initial wound evaluation completed on 4/28/09 included measurements. There were no subsequent measurements found for this open area. The facility failed to follow professional standards of practice for treatment of pressure ulcers by failing to ensure that weekly wound measurements were completed.</p> <p>Observation of R1's buttocks on 6/11/09 at 7:05 AM revealed a healed area on the left posterior buttock/thigh. There were no other open areas observed.</p> <p>Findings were confirmed with E2 (DON), E3 (ADON) and E19 (Corporate Nurse) during a meeting on 6/11/09.</p>	F 281	<p>The Director of Nursing or designee will monitor documentation weekly, for compliance per facility policy for two (2) weeks, then monthly for six (6) months for analysis and recommendations and report findings during quarterly quality assurance meetings.</p>		
F 327 SS=D	483.25(j) HYDRATION	F 327			

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F 327	<p>Continued From page 8</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documents, as well as hospital records, it was determined that the facility failed to ensure that one (1) resident (R2) out of 5 sampled, received sufficient fluid intake to maintain proper hydration and health. The facility failed to maintain R2's, with known risk for dehydration, fluid intake to ensure adequate hydration. A lack of monitoring resulted in the facility's failure to identify R2's increased risk of dehydration in a timely manner. R2 was not meeting his fluid needs for 6 weeks and was found to have abnormal laboratory values, dehydration and UTI (urinary tract infection). This resulted in R2 being sent to the hospital ER (emergency room) for diagnoses of dehydration/UTI and for intravenous (IV) access when an IV could not be started in the facility. Findings include:</p> <p>The facility's policies entitled "Hydration Management" and "Fluid Intake and Output Measurement" were reviewed.</p> <p>R2 had diagnoses that included Chronic Kidney Disease stage III (moderate), hypertension, paralysis agitans (Parkinson's Disease), pacemaker, PVD (peripheral vascular disease), anxiety disorder, history of dysphagia, osteoarthritis and UTIs. In addition, R2 had a suprapubic catheter. According to the significant change Minimum Data Set (MDS) assessment,</p>	F 327	<p>Resident #2's care plan has been updated to reflect measures to be taken to prevent hydration. The food & beverage department sends 480cc fluids with each meal and nursing provides 180cc fluids every shift.</p> <p>The Director of Nursing or designee will evaluate all residents I & O for fluid needs vs. actual intake and formulate a plan of care to meet their needs.</p> <p>The Director of Nursing or designee will in-service the nursing staff on the facility's I & O hydration policy which outlines the procedure for alternatives if residents do not meet fluid intake needs.</p> <p>The Director of Nursing or designee will monitor residents I & O daily for two (2) weeks until compliant, then weekly, then monthly for six (6) months for analysis and recommendations and will report findings during quarterly quality assurance meetings.</p>	7/30/09

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F 327	<p>Continued From page 9</p> <p>dated 4/8/09, R2's cognitive skills for daily decision-making were independent. R2 was totally dependent of staff for all activities of daily living (ADLS) except eating for which he was independent with setup help only. R2 was on anti-hypertensive and cardiac medications such as Norvasc and Atenolol.</p> <p>According to R2's "Nutritional Assessment" dated 3/21/09, his estimated daily fluid needs were "2222cc" per day. A care plan on "Nutrition: Therapeutic Diet R/T HTN" established on 3/28/09 and revised on 4/9/09, identified the goal "Will not exhibit s/s of dehydration." The interventions included "assist with meals as needed...Monitor for s/s (signs and symptoms) of dehydration." Another care plan was initiated on 4/9/09 for "Potential for complications R/T (related to) suprapubic catheter (UTI, dehydration...etc.)." The interventions included "Monitor urinary output for amount...q (every) shift...Notify MD of any changes...I&O (intake and output) q shift..." The care plan failed to include measures to be taken to prevent dehydration and failed to identify R2's daily fluid needs. Additionally, the care plan failed to identify alternate approaches to be implemented should R2 refuse fluids and not meet his daily fluid requirement.</p> <p>The facility initiated a daily "Intake and Output (I&O) Record" on 4/10/09. The I&O included a "Weekly Evaluation of Intake and Output." Review of R2's daily I&O sheets from 4/10/09 to 5/20/09 indicated that his average fluid intake was from 822 cc to 1522 cc below his required fluid needs of 2222cc/day. In addition his fluid output differs significantly with his fluid intake (too low or too high). On 5/18/09 E6 (Nurse Practitioner-NP) ordered a BMP (Basal Metabolic Panel) and a</p>	F 327		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 327	<p>Continued From page 10</p> <p>urine culture and sensitivity. Interview with E6 on 6/11/09 revealed that the blood and urine tests were ordered as a result of a family member's concern that something was not right with the resident. According to E6, laboratory tests were ordered to check R2's electrolytes. According to a nurse's note dated 5/21/09, E6 was notified of the abnormal blood and urine laboratory test result and ordered to "Push Fluid" at "2 liters/day". E6 confirmed that she was not informed by the nursing staff that R2 was not meeting his fluid needs.</p> <p>A nurse's note dated 5/21/09 stated, "Received new orders for repeat U/A/C&S (urinalysis/culture and sensitivity), BMP repeat Tuesday 5/26/09, Push Fluids 2L/Day...NP spoke with (family member) and resident suggested to be sent out to hospital. (Family member) + resident refuse hospitalization..."</p> <p>On 5/21/09 R2's I&O sheet indicated that this resident's total fluid intake was 1760/day and on 5/22/09 his fluid intake was 2540cc/day which met his required fluid needs. However, from 5/23/09 through 5/27/09 R2's fluid intake had a total average of 522 cc/day to 1020 cc/day which was below his required fluid needs.</p> <p>Interview with E2 (DON) and E5 (RN) on 6/11/09 at 11:45 AM confirmed that the documented total amount of fluid intake on R2's I&O record were accurate. E5 confirmed that the 24-hour total of fluid intake and output are calculated each day by the 11-7 AM shift. The "Weekly Evaluation of I&O" section was left blank on the I&O sheets that were reviewed from 4/10/09 to 5/28/09. Although the facility was completing the I&O sheets, there was no evidence that they were evaluating and</p>	F 327		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
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NAME OF PROVIDER OR SUPPLIER

FOULK MANOR NORTH

STREET ADDRESS, CITY, STATE, ZIP CODE

**1212 FOULK ROAD
WILMINGTON, DE 19803**

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F 327	<p>Continued From page 11</p> <p>identifying a lack of fluid intake and that a system was in place to report it to the next shift and to the physician when the resident was not meeting his fluid goal.</p> <p>A nurse's note dated 5/27/09 stated, "IV nurse present to start IV for resident. IV nurse attempted several times both veins collapsing...received orders from E8 (physician on call) to send to hospital for RX (treatment) and Eval. (evaluation) Dehydration and RX UTI...sent to the hospital ER..." The facility's Interagency Clinical Status Information form, completed on 5/27/09 at approximately 10 PM, stated "Reasons for transfer: IV's could not be started. Vein collapsing (lt) & (rt) arm per IV nurse. Sending to hospital for RX dehydration/UTI".</p> <p>The emergency department "Assessment Sheet/Interdisciplinary Record" noted the resident arrived in the ER on 5/27/09 at 2340 (11:40 PM) and stated, "Sent from NH (nursing home) for IV access." This same ER record noted that at 1:21 AM (on 5/28/09) an IVR (IV access) was inserted into R2's left hand. R2 was then discharged from the ER at 3:50 AM and sent back to the facility. A nurse's note dated 5/28/09 and timed 11:25 AM stated that IV fluids of NSS (9%) started this AM at 60 cc/hr. Another 1000cc of IV 0.9 NSS was infused on 5/29/09 and was discontinued after it was completed per physician's order. A total of 2 liters (2000cc) of IV fluid was administered in the facility.</p> <p>R2's laboratory blood work results, dated 5/26/09 (prior to hospitalization) were as follows: BUN 26 mg/DL (normal range-8-23); BUN/Creatinine ratio was 28.9 mg/DL (normal range-12-20). On 5/29/09 (post IV infusion) his BUN was 20 mg/DL</p>	F 327		

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F 327	Continued From page 12	F 327		
F 387	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS	F 387	Resident #1's physician came in to visit resident on June 29, 2009. The Facility sent resident #1's physician a letter reminding him of state and federal regulations for physician visits to maintain privileges at the facility.	7/30/09
SS=D	<p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that one (1) resident (R1) out of five (5) sampled was seen by a physician at least once every 60 days. Findings include:</p> <p>R1 was originally admitted to the facility on 10/24/01. Review of physician's progress notes revealed that the attending physician had seen R1 on 7/24/08. On 11/4/08 the facility's Medical Director wrote a progress note that stated, "left message (with) Dr. (name) on answering machine notifying of late signing orders + rec. (recertification) visit." R1 was next seen by her attending physician on 12/11/08, almost five (5) months after his last visit.</p> <p>The last documented physician visit progress note in R1's clinical record was dated 2/26/09. There was no evidence of any attending physician visits for the past 4 months.</p> <p>Findings were confirmed with E1 (Administrator),</p>		<p>The Director of Nursing or designee will review all residents' medical records to ensure compliance with physician visits. Physicians out of compliance will be notified, by letter, of federal and stated requirements for physician visits.</p> <p>The Director of Nursing or designee will in-service nurses on proper procedures required by physician visits. A list of residents requiring recertification visits will be compiled monthly. Physicians will be notified, via fax, one (1) week prior to visit (see attachment).</p> <p>The Director of Nursing or designee will monitor monthly, for six (6) months, for analysis and recommendations and report findings during quarterly quality assurance meetings.</p>	

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F 387	Continued From page 13	F 387		
F 441	E2 (Director of Nursing) and E3 (Assistant Director of Nursing) on 6/12/09.	F 441		
SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's policy, it was determined that the facility failed to ensure that three (3) staff (E11, E12 and E13) of twenty-eight (28) sampled received the tuberculin test required for new and current employees. Findings include: Three (3) staff (E11, E12 and E13) of twenty-eight (28) sampled revealed no record of tuberculosis testing. E11 was hired 9/24/04, E12 was hired 12/20/03, and E13 was hired 12/11/08. E12 was administered a tuberculin skin test on 6/9/09 and the result was pending. An interview with E3 (Assistant Director of Nursing) on 6/11/09 confirmed these findings. Review of the Employee Health Program policy, dated 3/22/02, stated that new employees will be administered a baseline TB skin test using the two-step method and that PPD-negative	<p>The three (3) staff members have received their tuberculosis testing. E11 received hers on 7/29/09, E12 6/9/09 and E13 7/29/09.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The Human Resources Manager will review all staff records to ensure all staff members are current for new hires and annual testing.</p> <p>The Human Resources Manager will maintain a checklist to track all staff members for compliance. A letter will be mailed to staff members due to receive their annual tuberculosis testing.</p> <p>Findings will reported during quarterly quality assurance meetings for analysis and follow-up recommendations.</p>	7/30/09	

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F 441	Continued From page 14 employees will have the skin test re-administered at regular intervals.	F 441		
F 497 SS=B	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation and staff interview, it was determined that the facility failed to insure that two (2) (E14 and E15) of three (3) sampled nursing assistants received the mandatory annual performance review. Findings include: 1. E14 was hired 10/5/01. The date of the latest evaluation in the personnel file was 10/22/07. 2. E15 was hired 4/5/03. Review of the performance evaluation in the personnel file revealed the absence of any signatures. An interview on 6/10/09 with E17 (Human Resources Specialist) confirmed these findings.	F 497	Employee #14 was hired on 10/5/01. He received an annual merit increase on 10/10/08. Employee #15 was hired on 4/5/03. Although she was given a performance review, it was not signed by her until 7/8/09. All residents have the potential to be affected by the stated deficiency. The Human Resources Manager will review all staff records to ensure all staff members are current for their annual performance review and maintain a checklist to track all staff members for compliance. Findings will be reported during quarterly quality assurance meetings for analysis and follow-up recommendations.	7/30/09

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F 502 SS=D	<p>483.75(j)(1) LABORATORY SERVICES</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to obtain laboratory services to meet the needs of one (1) resident (R1) out of five (5) sampled. Findings include:</p> <p>Cross refer to F387 Review of R1's monthly physician's order sheet (POS), dated 6/09 revealed the following laboratory orders: (dated 9/25/08): ALT/AST (screen for liver damage) every 6 months Feb/Aug. (dated 11/10/08): BMP (Basic metabolic Panel), CBC (Complete Blood Count), HGA1C (measures blood glucose levels), Lipid Panel, LFTS (liver function tests) every 6 months due Feb/Aug.</p> <p>R1's clinical record lacked evidence that the 2/09 laboratory tests had been obtained. The facility failed to obtain laboratory services in 2/09, as ordered by the physician</p> <p>A "Pharmacist/Physician Communication" sheet, dated 5/6/09 noted that R1 was missing current laboratory work. Although the facility faxed this communication sheet to the attending physician on 5/8/09, there was no evidence that he had responded. The facility failed to follow up regarding the lack of a response from the</p>	F 502	<p>Resident #1's physician was notified and labs were re-drawn on June 10, 2009. Results were faxed to physician on June 10, 2009.</p> <p>The Director of Nursing or designee will review all resident records for the past three (3) months to ensure that results are on the chart and resident's physician has been notified.</p> <p>The Director of Nursing or designee will in-service nurses on procedures. The facility has implemented a system for documenting the date lab results were obtained and date of physician notification.</p> <p>The Director of Nursing or designee will monitor lab orders and specimen logs for compliance for six (6) months for analysis and recommendations and report findings during quarterly quality assurance meetings.</p>	7/30/09

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F 502	Continued From page 16 attending physician and failed to ensure that R1 received necessary laboratory services. In an interview with E4 (nurse) on 6/10/09 at 3:10 PM, E4 confirmed the 2/09 labs had not been drawn. On 6/10/09 an order was written for R1 to have an "ALT/AST, LFTs, BMP, CBC, HGA1C, lipid panel stat (immediately)."	F 502			
F 518 SS=D	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interviews, it was determined that the facility failed to ensure the three (3) staff (E9, E11 and E12) of fifteen (15) sampled received annual fire/safety training. Findings include: E9 was hired 11/12/98, E11 was hired 9/24/04, and E12 was hired 10/20/03. The facility failed to provide any documented evidence of fire/safety training for E9, E11 and E12. An interview with E3 (Assistant Director of Nursing) on 6/11/09 confirmed these findings. An interview with E18 (Director of Facilities) revealed that fire/safety training is administered at least annually.	F 518	No residents were cited or identified by the stated deficiency. The three (3) staff members will be in-serviced on abuse training. No residents have been identified. Three (3) staff members will be in- serviced on abuse training. The Human Resources Manager will schedule monthly training, in-servicing and orientation for new hires and annually for existing staff. The Human Resources Manager will conduct a total review of all employee records to ensure compliance with abuse training and report findings at the next quality assurance meeting on July 20, 2009. Any staff not in compliance will be in-serviced. All findings will be reported during quarterly quality assurance meetings for analysis and follow-up recommendations.	7/30/09	



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JUL 17 2009

Director's Office

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STATE SURVEY REPORT

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: June 12, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.6.0</p> <p>3201.6.1</p> <p>3201.6.1.1</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from June 9, 2009 through June 12, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was 42. The survey sample totaled seven (7) residents (R1 through R7), which included five (5) active records and two (2) closed records. Additionally, there were two (2) sub sampled residents (SSR8 and SSR9) included for observation and interview only.</p> <p>Skilled and Intermediate Care Nursing Facilities</p> <p>Services To Residents</p> <p>General Services</p> <p>The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and</p>	<p>Responses to the cited deficiencies do not constitute an admission agreement by Foulk Manor North of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.</p>

Provider's Signature

Debra C. Gray NHA

Title

Executive Director

Date

July 16, 2009



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	<p>psychosocial needs.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 6/12/09, F327, F387 and F502.</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that one (1) resident (R6) out seven (7) sampled received the care necessary to meet her medical needs. The facility failed to obtain and monitor laboratory tests for R6 who was receiving the medications Zetia (used to lower cholesterol) and Synthroid (replacement therapy for hypothyroidism). Findings include:</p> <p>R6 was admitted to the facility on 9/19/08 and had diagnoses that included hypothyroidism, hypertension and dementia. Review of R6's clinical record revealed that the resident was receiving Zetia 10 mg tablet once daily and Synthroid 50 mcg tablet once daily since admission.</p> <p>According to the Lexi-Comp's Drug Reference Handbook "Drug Information Handbook for Nursing" 8th Edition, Zetia therapy should include "... monitor laboratory tests (lipid profile)...at the beginning of and at regular intervals during</p>	<p>Cross-refer to CMS 2567-L survey date completed 6/12/09, F327, F387 and F502.</p>



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	<p>therapy..." This same handbook states that during Synthroid therapy "doses should be adjusted based on clinical response and laboratory parameters."</p> <p>R6's clinical record revealed a "Pharmacist/Physician Communication" sheet, dated 11/10/08 which stated, "Resident has been receiving Zetia and levothyroxine (Synthroid) without current lab work on the chart. Recommendation: Please consider order (sic) a lipid panel, thyroid panel and LFTs (liver function tests)." The facility's Nurse Practitioner (NP) responded to the Pharmacist communication on 11/13/08 stating that the suggestions had been read and no changes were to be implemented at this time. The NP also stated that laboratory results had been obtained from an outside source and that new laboratory tests would be obtained in 12/08.</p> <p>Review of R6's clinical record revealed that there had been no laboratory tests drawn for a lipid panel, thyroid panel or LFTs since R6's admission to the facility on 9/19/08. The facility failed to obtain laboratory tests for R6 to monitor for adverse effects of these medications and ensure correct dosage.</p> <p>Findings were confirmed with E2 (DON), E3</p>	



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3201.6.5	(ADON) and E19 (Corporate Nurse) during a meeting on 6/11/09.	
3201.6.5.6	<p>Nursing Administration</p> <p>A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 6/12/09, F279.</p>	
3201.6.5.7	<p>The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan</p>	<p>Cross-refer to CMS 2567-L survey date completed 6/12/09, F279.</p>



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STATEMENT OF DEFICIENCIES Specific Deficiencies		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
SECTION		
	shall be developed at least yearly from the date of the last full assessment.	
	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L survey date completed 6/12/09, F280.	Cross-refer to CMS 2567-L survey date completed 6/12/09, F280.
3201.6.6	Activities	
3201.6.6.1	The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the needs, interests, abilities, preferences, limitations and age of each resident.	
	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L survey date completed 6/12/09, F248.	Cross-refer to CMS 2567-L survey date completed 6/12/09, F248.
3201.6.12	Communicable Diseases	
3201.6.12.2	Specific Requirements for Tuberculosis	
3201.6.12.2.3	All facilities shall have on file results of	



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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
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	<p>tuberculin tests performed on all newly admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 6/12/09, F441.</p> <p>4-601.11 (B) Cleaning of Equipment and Utensils</p> <p>Muffin pans, 2 and 12 inch pans were immediately removed from the ready-to use rack, cleaned and sanitized.</p> <p>The two (2) 14 inch diameter frying pans were immediately removed from service and discarded.</p> <p>The two (2) new 14 inch diameter frying pans were purchased, cleaned, sanitized and placed into service on the same day.</p>
3201.7.0	Plant, Equipment and Physical Environment
3201.7.5	Kitchen and Food Storage Areas
3201.7.5.1	Facilities shall comply with the Delaware Food Code.
	<p>This requirement is not met as evidenced by:</p> <p>Based on dietary observations throughout the survey, it was determined that the facility failed</p>



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	<p>to comply with sections 4-601.11 (B), 4-601.11 (C), and 4-903.11 (B) (1) of the State of Delaware Regulation Governing Public Eating Places. Findings include:</p> <p>4-6 Cleaning of Equipment and Utensils</p> <p>4-601.11 (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.</p> <p>This requirement is not met as evidenced by:</p> <p>Observations at 9:10 AM of the equipment stored on the ready-to-use rack revealed that the food-contact surfaces of four (4) muffin pans and a 2 and 1/2 inch rectangular steam table pan were soiled with grease deposits. Additionally, observations at 9:25 AM revealed that the food-contact surface of two (2) 14 inch diameter frying pans stored on an overhead rack was soiled with black encrusted debris. These findings were confirmed by E16 (Director of Food Service).</p> <p>4-601.11 (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p>	<p>The Food Service Manager(s)/supervisors will inspect the cleaning schedule, daily, to ensure completion of the form and audit the completed form against findings, to ensure accuracy and confirm sanitary conditions.</p> <p>A quality assurance cleaning schedule has been implemented and posted to ensure kitchen equipment is properly cleaned, sanitized, stored and maintained.</p> <p>The Food & Beverage Director will report all findings during the facility's quarterly quality assurance committee meetings.</p> <p>4-601.11 (C) Non-Food Contact Surfaces...</p> <p>The pellets (plate warmers) were immediately removed from service, cleaned and sanitized.</p> <p>A quality assurance cleaning schedule has been implemented and posted to ensure that kitchen equipment is properly cleaned, sanitized, stored and maintained.</p> <p>The Food Service Manager(s)/supervisors will inspect the cleaning schedule, daily, to ensure completion of the form and audit the completed form against findings, to ensure accuracy and confirm sanitary conditions.</p>



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	<p>This requirement is not met as evidenced by:</p> <p>Observations at 9:15 AM revealed that the upper surface of multiple pellets (plate warmers) stored in their respective plastic bottoms was soiled with grease debris. The pellets were removed from the plastic bottoms by E16.</p> <p>4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.</p> <p>(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored:</p> <p>(1) In a self-draining position that allows air drying.</p> <p>This requirement is not met as evidenced by:</p> <p>Observations at 9:08 AM of a stack of four (4) circular steam table pans revealed that the pans were dripping wet. This finding was confirmed by E16.</p> <p>Emergency Preparedness</p> <p>The staff on all shifts shall be trained on</p>
	<p>The Food & Beverage Director will report all findings during the facility's quarterly quality assurance committee meetings.</p> <p>4-903.11 Equipment, Utensils, Linen and...</p> <p>The four (4) circular steam tables pans were removed from their location, cleaned and</p> <p>A quality assurance cleaning schedule has been implemented and posted to ensure that kitchen equipment is properly cleaned, sanitized, stored and maintained.</p> <p>The Food Service Manager(s)/supervisors will inspect the cleaning schedule, daily, to ensure completion of the form and audit the completed form against findings, to ensure accuracy and confirm sanitary conditions.</p> <p>The Food & Beverage Director will report all findings during the facility's quarterly quality assurance committee meetings.</p> <p>Completion Date: September 12, 2009</p>
3201.8.0	
3201.8.4	



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16 Del. C., Chapter 11, § 1121	emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.
	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 6/12/09, F518.
	Patient's rights It is the intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following: (17) Each patient and resident shall have the right to retain and use the patient's or resident's own personal clothing and possessions where reasonable, and shall have the right to security in the storage and use of such clothing and possessions.
Cross-refer to CMS 2567-L survey date completed 6/12/09, F518.	



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This requirement is not met as evidenced by:

Based on facility incident report review and interview it was determined that the facility failed to ensure that one (1) sub sampled resident's (SSR8) personal belongings were secure. SSR8's eyeglasses were lost and the family had to have them replaced. Findings include:

SSR8 was admitted to the facility in April 2008 with a diagnosis of progressive dementia. The admission Minimum Data Set (MDS) assessment, dated 4/28/08 indicated that the resident wore eyeglasses. The quarterly MDS assessment, dated 7/15/08 identified that SSR8 had short and long term memory problems and that her cognitive skills for daily decision making were "severely impaired-never/rarely made decisions." This same MDS indicated SSR8 had periods of restlessness (e.g., fidgeting or picking at skin, clothing...).

A facility "Incident Report Form," dated 7/28/09 indicated that SSR8's eyeglasses were missing. The "Incident Report Follow-Up Investigation," dated 7/31/08 stated that the resident was alert but extremely confused, becomes very restless and agitated and spends much of the day at the nurse's station for one to one observation. Additionally, the

16 Del. C., Chapter 11, 1121 Patient's Rights

Resident SSR8's glasses have been replaced and has a chain attached to frames. The facility has taken responsibility for removing resident's glasses and placing them in treatment cart at HS for wear in the A.M.

The Director of Social Services/Healthcare Admissions, with the family member/responsible party's permission, will ensure that resident glasses, hearing aides and dentures be marked/labeled.

The Director of Social Services/Healthcare Admissions, will mark/label residents' personal items upon admission and with any changes.

The Director of Social Services/Healthcare Admissions, will report any concerns and/or updates during the facility's quarterly quality assurance committee meeting.

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	<p>follow-up report stated that the eyeglasses were seen at the nurse's station on 7/26/08 or 7/27/08. A search was conducted, however the eyeglasses were not found.</p> <p>During an interview with E1 (Administrator) on 6/11/09, E1 stated that in cases where a resident is totally dependent and staff misplaces an item, then the facility will reimburse the cost to the family. In a second interview with E1 on 6/12/09, E1 stated that SSR8 is "fidgety" and used to take off her eyeglasses and lay them down in random places. E1 also stated that the facility offered to have SSR8 be seen by the eye doctor who visited the facility, however the family preferred to have her see her own eye doctor. The family also paid for the cost of having the eyeglasses replaced.</p> <p>The facility failed to ensure that a cognitively impaired resident's personal belongings were secure in the facility.</p>	
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